

02485

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 62

2498

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Denton</u>	LENGTH OF STAY (in this place) <u>50 Yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Denton</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>		STREET ADDRESS (If rural give location) <u>None</u>	/
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>John</u>	(Middle)	(Last) <u>Baynard Sr.</u>	DATE OF DEATH: <u>3</u> <u>4</u> <u>55</u> <u>19</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>2/14/1878</u>
9. AGE last birthday <u>77</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Baynard</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Ann Hurd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-26-2778</u>	
17. INFORMANT & ADDRESS: <u>Landa Baynard Denton, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>420.1 acute coronary occlusion</u>			<u>four minutes</u>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>arteriosclerosis</u>			<u>5 years</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 29</u> , 19 <u>44</u> , to <u>March 4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>March 4</u> , 19 <u>55</u> , and that death occurred at <u>2:45</u> A.M., from the causes and on the date stated above.			
SIGNATURE <u>Paul Throth</u>		DATE SIGNED <u>3-5-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/7/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/5/55</u>		REGISTRAR'S SIGNATURE <u>Dr. O. George</u>	
24. FUNERAL DIRECTOR <u>J. E. Boulaie</u>		ADDRESS <u>Greensboro, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

MAR 10 1955

RECEIVED

2499

CERTIFICATE OF DEATH

Reg. Dist. No. 62..

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Rural Denton</u>	LENGTH OF STAY (in this place) <u>life</u>	CITY (If outside corporate limits, write RURAL OR TOWN <u>Rural Denton</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	<u>1</u>
3. NAME OF DECEASED: (Type or Print) <u>NANCY</u> (First) <u>CORKRELL</u> (Last)		4. DATE OF DEATH: (Month) <u>MAR</u> (Day) <u>23</u> (Year) <u>1955</u>	
5. SEX: <u>7</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>1901</u>
9. AGE last birthday: <u>54</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY: <u>housewife</u>	
11. BIRTHPLACE (State or foreign country): <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>China Thomas</u>		14. MOTHER'S MAIDEN NAME: <u>Lida Porter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY NO.: <u>-</u>	
17. INFORMANT & ADDRESS: <u>Mrs. John Corkrell, Denton, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
442X Immediate cause (a) <u>Cerebral Hemorrhage</u>		3 hrs	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Endokrinial Disease & Hypertension</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. (c) <u>Chr. Chole Cystitis</u>			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 8, 1954</u> , to <u>Mar. 23, 1955</u> , that I last saw the deceased alive on <u>Mar. 22, 1955</u> , and that death occurred at <u>Denton, Md.</u> from the causes and on the date stated above.			
SIGNATURE <u>Charles H. Streifer M.D.</u>		ADDRESS <u>P.O. Box 1855</u>	
DATE SIGNED <u>Mar. 25, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
LOCATION (City, town, or county) (State)			
DATE REC'D BY LOCAL REGISTRAR <u>3/25/55</u>		FURNERAL DIRECTOR <u>J. Vigil</u>	
REGISTRAR'S SIGNATURE <u>Wm. D. George</u>		ADDRESS <u>Denton, Md.</u>	

RECEIVED

MAR 29 1955

BUREAU V. S.

02487

MARYLAND

STATE DEPARTMENT OF HEALTH

2570

CERTIFICATE OF DEATH

Reg. Dist. No.

I. PLACE OF DEATH- COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1st Ave. West. extended</u>		STREET ADDRESS (If rural, give location) <u>14X-2</u>	
3. NAME OF DECEASED (Type or Print) <u>Edgar Nelson Cully</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 21 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Mar. 10 1873</u> 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>	
11. BIRTHPLACE (State or foreign country) <u>Kent Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Mary Shinn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Claudia Guthrie - Ridgely Ind.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
420.1 Immediate cause (a) <u>Chronic coronary thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>During sleep.</u> <u>Years.</u>	
Antecedent cause(s) (b) <u>Hypertension - myocardial failure</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Gravel like uric acidosis</u> <u>Cerebral arteriosclerosis</u>			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <u>March 3, 1955 March 4, 1955</u>	
22. I hereby certify that I attended the deceased from <u>March 3, 1955</u> to <u>March 4, 1955</u> , that I last saw the deceased alive on <u>March 3, 1955</u> and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Charles H. Winkler</u> (Deputy or title)		ADDRESS <u>Ridgely, MD</u> DATE SIGNED <u>Mar. 21, 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>3/23/55</u> NAME OF CEMETERY OR CREMATORY <u>Wash. Chapel Cemetery</u> LOCATION (City, town, or county) (State) <u>Rock Hall, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>March 21, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary C. Laird</u> 24. FUNERAL DIRECTOR <u>Marvin V. Williams - Cheltenham Ind.</u> ADDRESS	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAR 23 1955

RECEIVED

2501

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Preston</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Preston</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>1</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) (Middle) (Last) <u>Peter</u> <u>deWilde</u>		<u>March 1</u> <u>1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>May 24, 1877</u>
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
<u>77</u> yrs.		<u>Holland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Farmer</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Cornelius deWilde</u>		<u>Dina Bustraan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>		<u>None</u>	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Mrs. Maria deWilde, Preston, Maryland</u>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A)		<u>Chronic Congestive Heart Failure</u>	
ANTECEDENT CAUSE (S)		<u>10 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>1 yr</u>	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6/10</u> , 19 <u>58</u> , to <u>3/1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/1</u> , 19 <u>58</u> , and that death occurred at <u>10:45 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>James D. Plummer</u>		DATE SIGNED <u>3/8/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR ADDRESS	
<u>Burial</u>		<u>J.J. Frampton and Son, Federalsburg, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-4-55</u>		REGISTRAR'S SIGNATURE <u>Cornelia D. Plummer</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 7 1955

RECEIVED

2502

CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Caroline</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Caroline</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rural Denton</i>	LENGTH OF STAY (in this place) <i>30 yrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rural Denton</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) <i>MARTHA</i> (Middle) <i>STEPHANIE</i> (Last) <i>HENNINGS</i>		4. DATE OF DEATH: (Month) <i>Mar</i> (Day) <i>18</i> (Year) <i>1955</i>	
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widowed</i>	8. DATE OF BIRTH: <i>Dec 26, 1872</i>
9. AGE last birthday: <i>82</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <i>Coversewer</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Home</i>	
11. BIRTHPLACE (State or foreign country): <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME: <i>Henry Hoffman</i>		14. MOTHER'S MAIDEN NAME: <i>Lufkinson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>no</i>		16. SOCIAL SECURITY No.: <i>-</i>	
17. INFORMANT & ADDRESS: <i>Chas Boyd Reisel, Denton, Md.</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
<i>1450.0</i>		<i>12 years</i>	
Immediate cause (a) <i>arterio sclerosis</i>		<i>8 years</i>	
Antecedent causes (s) (b) <i>Parkinsons Disease</i>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY ?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR ?			
22. I hereby certify that I attended the deceased from <i>Jul 28</i> , 1955, to <i>Mar 18</i> , 1955, that I last saw the deceased alive on <i>Mar 16</i> , 1955, and that death occurred at <i>12:30 AM</i> , from the causes and on the date stated above.			
SIGNATURE <i>St Paul Smith MD</i>		DATE SIGNED <i>3-21-55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>Mar 24, 1955</i>	
NAME OF CEMETERY OR CREMATORY <i>Denton</i>		LOCATION (City, town, or county) (State) <i>Denton, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>3/24/55</i>		REGISTRAR'S SIGNATURE <i>MAO George</i>	
24. FUNERAL DIRECTOR <i>J. Vigil</i>		ADDRESS <i>Worship, Denton, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 24 1955

BUREAU V. S.

2533

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rural Greensboro</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Greensboro</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>		STREET ADDRESS (If rural give location) <u>None</u>	
3. NAME OF DECEASED: (First) <u>George</u> (Middle) <u>Joseph</u> (Last) <u>Kibler</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>3</u> <u>6</u> <u>55</u> <u>19</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>8/27/1903</u>
9. AGE last birthday: <u>51</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farm Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Louis Kibler</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Schreiber</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-30-7985</u>	
17. INFORMANT & ADDRESS: <u>Anne Bradford Greensboro, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Acute Myocarditis</u>			<u>4 hrs.</u>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Viral enteric virus infection</u>			<u>4 hrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>E. coli (fecal oral)</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 6, 1955</u> to <u>Mar. 6, 1955</u> that I last saw the deceased alive on <u>Mar. 6, 1955</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Charles H. S. Macfarlane</u>		DATE SIGNED <u>March 7, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/9/55</u>	
NAME OF CEMETERY OF CREMATION <u>Holy Cross</u>		LOCATION (City, town, or county) (State) <u>Near Greensboro, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Mar. 9, 1955</u>		REGISTRAR'S SIGNATURE <u>L. M. Pappin</u>	
24. FUNERAL DIRECTOR <u>J. E. Boulaire</u>		ADDRESS <u>Greensboro, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 11 1955

BUREAU V. S.

2504

CERTIFICATE OF DEATH

Reg. Dist. No. 66

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>X</u> <u>Rural Ridgely</u>		<u>66 Yrs.</u>		<u>Rural Ridgely</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>None</u>				<u>None</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First)		(Middle)		(Last)			
<u>Marshall</u>		<u>Francis</u>		<u>Lockman</u>		<u>3 6 55</u>	
(Type or Print)						<u>19</u>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<u>Male</u>		<u>Col.</u>		<u>Married</u>		<u>7/15/1888</u>	
						9. AGE last birthday	
						<u>66</u> yrs.	
						IF UNDER 1 YEAR	
						Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:			
<u>Farm Laborer</u>				<u>None</u>			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
<u>Maryland</u>				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Cherry Lockman</u>				<u>Mary Armstrong</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>No</u>				<u>218-09-5825</u>			
17. INFORMANT & ADDRESS:							
<u>Hattie Lockman Ridgely, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)							
<u>442X</u> <u>Cardiovascular Renal Disease</u>							
ANTECEDENT CAUSE (B)							
<u>Cerebral's general cerebral sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY?							
YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
OF INJURY		While <input type="checkbox"/> Not while <input type="checkbox"/>					
M.		at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Nov. 22, 1954</u> , to <u>Mar. 6, 1955</u> , that I last saw the deceased alive on <u>Mar. 5, 1955</u> , and that death occurred at <u>5 A.</u> M., from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Robert H. Funderburk</u>		<u>Greensboro Md.</u>		<u>Mar. 7, 1955</u>			
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/9/55</u>		<u>Denton</u>		<u>Denton, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>3/9/55</u>		<u>Mary E. Laird</u>		<u>J. E. Boulaie</u>		<u>Greensboro, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 14

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2505

CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Greensboro</u> <u>25 Yrs.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS (If rural give location) <u>None</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Frank Finch Manship</u>				OF DEATH: <u>3</u> <u>25</u> <u>55</u> <u>19</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>1/3/1880</u>	<u>75</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Machine Shop Pet Milk Co.</u>			<u>None</u>	<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Andrew Manship</u>				<u>Lida Tinley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>217-05-7885</u>		<u>Cora Manship Greensboro, Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>442X</u>							
IMMEDIATE CAUSE							
(A) <u>Cardio Vascular Renal Disease</u>							
DUE TO							
ANTECEDENT CAUSE (S)							
(B) <u>General Arteriosclerosis</u>							
DUE TO							
(C) <u>Coronary Sclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 22, 1954</u> , to <u>Mar. 25, 1955</u> , that I last saw the deceased alive on <u>Mar. 25, 1955</u> , and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Clark X Huescher</u>		M.D. <u>Glenn H. Huescher</u>		ADDRESS <u>Greensboro, Md.</u>		DATE SIGNED <u>March 28, 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/29/55</u>		<u>Greensboro</u>		<u>Greensboro, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>Mar 29-1955</u>		<u>L. M. Lippin</u>		<u>J. E. Boulaie</u>		<u>Greensboro, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 30 1955

RECEIVED

2506

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

COUNTY Caroline MARYLAND
 CITY (If outside corporate limits, write RURAL) LENGTH OF STAY
 OR and give nearest town) (in this place)
 X TOWN Newton Rd.
 HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Ind COUNTY Caroline
 CITY (If outside corporate limits, write RURAL, and give nearest town) X
 OR TOWN Newton Rd.
 STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED:

(First) (Middle) (Last)
Howard Parter
 (Type or Print)

4. DATE OF DEATH: (Month) (Day) (Year)
Mar. 10 1955

5. SEX:

M

6. COLOR OR RACE:
W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
Married

8. DATE OF BIRTH:

Mar. 10 1881

9. AGE last birthday: 74 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired.
Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):
Ind. Newton Rd.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME:

Charles Parter

14. MOTHER'S MAIDEN NAME:

Margaret Garrett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
no

16. SOCIAL SECURITY No.:

—

17. INFORMANT & ADDRESS:

Chas. Parter, Newton

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

431X
 Immediate cause

(a) DUE TO

Myocarditis Acute

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

Interval Between Onset And Death

2 days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Arturo Solano

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1944, to Mar. 10, 1955, that I last saw the deceased

alive on 3-10, 1955, and that death occurred at 4:45 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL - (Specify)

Buried Mar. 15

NAME OF CEMETERY OR CREMATORY
Newton Cemetery

LOCATION (City, town, or county)
Newton

(State)
Ind.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

Mar. 13-1955 L. M. Pappas J. Virgil Moore & Sons Newton

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 16 1955

BUREAU V. S.

2507

CERTIFICATE OF DEATH

Reg. Dist. No. 60

02494

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Caroline</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Caroline</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Templeville</i>		LENGTH OF STAY (in this place) <i>80 yrs.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Templeville</i>		OR TOWN <i>Templeville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>None</i>				STREET ADDRESS (If rural give location) <i>None</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<i>ANNIE THOMPSON SATTERFIELD</i>				OF DEATH: <i>3 18 1955</i>			
5. SEX: <i>F.</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Married</i>	8. DATE OF BIRTH: <i>10/3/1874</i>	9. AGE last birthday <i>80</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY: <i>None</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME: <i>William Thompson</i>			
14. MOTHER'S MAIDEN NAME: <i>Larrah Nickerson</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO. <i>None</i>				17. INFORMANT & ADDRESS: <i>Geo. Satterfield Templeville, Md.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>My percutaneous Heart Disease</i>						<i>5 yrs</i>	
ANTECEDENT CAUSE (S) (B) <i>Generalized Arteriosclerosis</i>						<i>10</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <i>None</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>None</i>							
19A. DATE OF OPERATION: <i>None</i>				19B. MAJOR FINDINGS OF OPERATION: <i>None</i>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR? <i>None</i>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>No Injury</i> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>May 3/19 1-2</i> to <i>May 15, 19 55</i> , that I last saw the deceased alive on <i>Mar 18, 19 55</i> , and that death occurred at <i>5:40 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>J.H. Hamilton</i>				DATE SIGNED <i>3/19/55</i>			
M.D. <i>Hullington Md</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>3/21/55</i>		NAME OF CEMETERY OR CREMATORY <i>Busic</i>		LOCATION (City, town, or county) (State) <i>Near Templeville, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>3/21/55</i>		REGISTRAR'S SIGNATURE <i>A. Clark Smith</i>		24. FUNERAL DIRECTOR <i>J.E. Boulaire Greensboro, Md.</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10

BUREAU V. S.

APR 5 1955

RECEIVED

100-100000

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02495

2578

CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Rural Greensboro X	
X TOWN <u>Rural Greensboro</u>		<u>51 Yrs.</u>		STREET ADDRESS (If rural give location)		<u>None</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Lawrence George Schreiber</u>				<u>3 14 55 19</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>3/20/1903</u>	
9. AGE last birthday: <u>51</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>George P. Schreiber</u>		14. MOTHER'S MAIDEN NAME: <u>Josephine Brogely</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u>		16. SOCIAL SECURITY NO.: <u>220-12-5336</u>		17. INFORMANT & ADDRESS: <u>Kathryn Schreiber Greensboro, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CardioVascular Renal Disease</u>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Malignant Hypertension</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 15, 1954</u> , to <u>Mar. 14, 1955</u> , that I last saw the deceased alive on <u>Mar. 14, 1955</u> , and that death occurred at <u>12:20 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Charles H. Hunsicker</u>		M. D. <u>Greensboro</u>		DATE SIGNED <u>March 17, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/17/55</u>		<u>Holy Cross</u>		<u>Greensboro, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Mar. 17-1955</u>		REGISTRAR'S SIGNATURE <u>L. M. Peppin</u>		24. FUNERAL DIRECTOR <u>J. E. Boulois</u>		ADDRESS <u>Greensboro, Md.</u>	

BUREAU V. S.

MAR 23 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. *62*

1. PLACE OF DEATH <i>2599</i>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Caroline</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Caroline</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Purton, Rd.</i>	LENGTH OF STAY (in this place) <i>Life</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Purton, Rd.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>		STREET ADDRESS (If rural give location) <i>1</i>	

3. NAME OF DECEASED: (First) (Middle) (Last) <i>Birivan William Smith</i>		4. DATE OF DEATH: (Month) (Day) (Year) <i>Mar. 15 1955</i>	
5. SEX: <i>M.</i>	6. COLOR OR RACE: <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Aug. 3, 1877</i>
9. AGE last birthday: <i>77</i> yrs.		10. BIRTHPLACE (State or foreign country): <i>England</i>	
11. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Farmer</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Charles F. Smith</i>		14. MOTHER'S MAIDEN NAME: <i>Mrs. Nina Smith (wife)</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY No.: <i>—</i>	
17. INFORMANT & ADDRESS: <i>Mrs. Nina Smith (wife)</i>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<i>177X</i> Immediate cause (a) <i>Carcinoma of Prostate</i>		<i>18 mos</i>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO		
(c)		

II. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY ?
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input type="checkbox"/>
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, or office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
SUICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *2/19*, 19*54*, to *3/15*, 19*55*, that I last saw the deceased alive on *2/14*, 19*55*, and that death occurred at *4:05 AM* from the causes and on the date stated above.

SIGNATURE	(Degree or title)	DATE SIGNED
<i>3/16/55</i>	<i>Dr. J. G. Moore</i>	<i>3-16-55</i>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<i>Burial</i>	<i>Mar. 18, 1955</i>	<i>Purton</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<i>3/16/55</i>	<i>W. O. George</i>	<i>J. G. Moore</i>
		ADDRESS
		<i>Purton</i>

MARGIN RESERVED FOR BINDING

RECEIVED

MAR 22 1955

BUREAU V. S.

2510

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Caroline		MARYLAND		STATE Maryland		COUNTY Caroline	
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Preston - Rural		LENGTH OF STAY (in this place) Life		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Preston - Rural X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Harmony				STREET ADDRESS (If rural give location) Harmony			
3. NAME OF DECEASED: (First) (Middle) (Last) Harry Roland Towers				4. DATE (Month) (Day) (Year) OF DEATH: March 28 1955			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: January 31, 1887	9. AGE last birthday: 68 yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer			10B. KIND OF BUSINESS OR INDUSTRY: Farm Owner		11. BIRTHPLACE (State or foreign country): Caroline County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George W. Towers				14. MOTHER'S MAIDEN NAME: Julia E. Liden			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No			16. SOCIAL SECURITY No.: Unknown		17. INFORMANT & ADDRESS: G. Chester Towers, Landover, Maryland		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 420.1							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(A) DUE TO Acute Coronary Occlusion						1 minute	
(B) DUE TO Coronary Sclerosis & Insufficiency						10 yrs	
(C) DUE TO Generalized Arteriosclerosis						10 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes Mellitus Insulin Dependent						10 yrs	
19A. DATE OF OPERATION: ✓		19B. MAJOR FINDINGS OF OPERATION: ✓				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: — M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1/10 , 19 55 , to 3/28 , 19 55 , that I last saw the deceased alive on 3/15 , 19 55 , and that death occurred at 2 P.M. from the causes and on the date stated above.							
SIGNATURE Lucy B. Plummer		M. D. Preston Ry		DATE SIGNED 3/30/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF March 31, 1955		NAME OF CEMETERY OR CREMATORY Linchester Cemetery		LOCATION (City, town, or county) (State) Preston, Maryland	
DATE REC'D BY LOCAL REGISTRAR 3-30-55		REGISTRAR'S SIGNATURE Cornelia W. Plummer		24. FUNERAL DIRECTOR ADDRESS J.J. Frampton and Son, Federalsburg, Md.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 1 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

02498

2511

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH- COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <input checked="" type="checkbox"/> TOWN <u>rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Federalburg</u> <input checked="" type="checkbox"/>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Federalburg</u>		STREET ADDRESS (If rural, give location) <u>rural Allen Corner Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>John E. Towers</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 29, 1955</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>May 12, 1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE last birthday <u>79</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Towers</u>		14. MOTHER'S MAIDEN NAME <u>Sarah (last name unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT AND ADDRESS <u>J. Elwood Towers Federalburg, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<p>9/16.8 Immediate cause (a) <u>Asphyxiation</u></p> <p>Antecedent cause(s) (b) <u>Trapped in burning building</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)</p>		<u>See notes</u>

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
---	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE <u>accident</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>Home</u>	(CITY OR TOWN) <u>Federalburg</u> (COUNTY) <u>Caroline</u> (STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3-29-55 2nd m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Trapped in burning building</u>

22. I hereby certify that I attended the deceased from March 29, 1955, to March 29, 1955, that I last saw the deceased alive on March 29, 1955, and that death occurred at 2:00 m., from the causes and on the date stated above.

SIGNATURE <u>James D. George, Deputy Medical Examiner, Baltimore</u>	(Degree or title)	ADDRESS <u>Smithston Cemetery near Preston, Md.</u>	DATE SIGNED <u>3/29/55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>	DATE THEREOF <u>3/31/55</u>	NAME OF CEMETERY OR CREMATORY <u>Smithston Cemetery</u>	LOCATION (City, town, or county) (State) <u>near Preston, Md.</u>
DATE REC'D BY LOCAL REG. <u>March 30, 1955</u>	REGISTRAR'S SIGNATURE <u>Everett Nuttle, Deputy Registrar</u>	24. FUNERAL DIRECTOR <u>James D. George</u>	ADDRESS <u>Federalburg, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 4 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2512

CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>X</u> <u>Denton</u>		<u>Wife</u>		<u>Denton</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>405 High st</u>				STREET ADDRESS (If rural give location) <u>405 High st.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>William R Troxon</u>				OF DEATH: <u>3</u> <u>20</u> 19 <u>55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>Col</u>	<u>Single</u>	<u>3/14/98</u>	<u>57</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Merchant Store owner</u>		<u>Maryland</u>		<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Elijah Troxon</u>				<u>Mary Bosley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
				<u>—</u>		<u>Elyck Troxon-Denton</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE		(A) DUE TO <u>Coronary Occlusion</u>				<u>1 hr</u>	
ANTECEDENT CAUSE (B)		(B) DUE TO <u>Coronary Atherosclerosis</u>				<u>2 yr</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>4 yr</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-10, 1955</u> to <u>3-30, 1955</u> that I last saw the deceased alive on <u>3-30, 1955</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Dawson George</u>		M. D. <u>Denton Md</u>		ADDRESS <u>4/2/55</u>		DATE SIGNED <u>4/2/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/3/55</u>		<u>Sand town</u>		<u>Hillsboro Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>4-2-55</u>		<u>Wm B Gump</u>		<u>Jas. B. Ashwell - Denton Md -</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 5 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02500

2513

CERTIFICATE OF DEATH

Reg. Dist. No. 66

1. PLACE OF DEATH- COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Delaware</u> COUNTY <u>New Castle</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) X TOWN <u>Ridgely, Md Rural</u> LENGTH OF STAY (in this place) <u>17 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Townsend</u> <u>46 X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10</u>		STREET ADDRESS (If rural, give location) <u>Delaware R.D. 4</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Matthie</u> (Middle) <u>J.</u> (Last) <u>Van Horn</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3-22-1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>11-30-1867</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>86</u> yrs.
11a. BIRTHPLACE (State or foreign country) <u>Del.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Hanson Harris</u>		14. MOTHER'S MAIDEN NAME <u>Ribeca Mary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Osgers Prockery Townsend</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
450.0 Immediate cause		(a) <u>Myocardial Infarction, acute.</u>		3 days.	
Antecedent cause(s)		(b) <u>Atherosclerosis, Generalized</u>		years.	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) <u>Atherosclerosis, Generalized - Slightly</u>		4 years.	
II. OTHER SIGNIFICANT CONDITIONS		Dehydration - Pre-uremic			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb., 1953, to 3-22-, 1955, that I last saw the deceased alive on 3-22-, 1955, and that death occurred at 3:45 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	DATE <u>3-25-55</u>	NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	LOCATION (City, town, or county) <u>Chapin City, Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>Mar. 23, 1955</u>	REGISTRAR'S SIGNATURE <u>Mary E. Laird</u>	24. FUNERAL DIRECTOR <u>G. J. ...</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 28 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2514

CERTIFICATE OF DEATH

02502

Reg. Dist. No. 41

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Greensboro</u>	LENGTH OF STAY (in this place) <u>72 Yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Greensboro</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> <u>None</u>		STREET ADDRESS (If rural give location) <u>None</u>	<u>/</u>
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Wilmer</u>	(Middle)	(Last) <u>Webber</u>	OF DEATH: <u>3</u> <u>16</u> <u>55</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE. MARRIED. WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>5/8/1882</u>
9. AGE last birthday: <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Laborer</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>William Webber</u>	
14. MOTHER'S MAIDEN NAME: <u>Maggie Todd</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>220-03-3557 A</u>		17. INFORMANT & ADDRESS: <u>Katie Webber Greensboro, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>			
ANTECEDENT CAUSE (B) <u>Arteriosclerotic Cardiovascular Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 1, 1954</u> to <u>Mar. 16, 1955</u> , that I last saw the deceased alive on <u>Mar. 16, 1955</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Charles H. Hensley</u>		DATE SIGNED <u>March 17 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/19/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Mar. 19-1955</u>		REGISTRAR'S SIGNATURE <u>L. M. Lippin</u>	
J. E. BOULAS		ADDRESS <u>Greensboro, Md.</u>	

BUREAU V. S.

MAR 23 1955

RECEIVED

2515

CERTIFICATE OF DEATH

Reg. Dist. No. 66

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Ridgely</u>	LENGTH OF STAY (in this place) <u>509-1</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>Harman</u> <u>Wilson</u>		<u>Mar. 15th</u> 19 <u>55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Dec. 14th 1877</u>
9. AGE last birthday: <u>77</u> yrs.		10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.	
11. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Mechanics</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James B. Wilson</u>		14. MOTHER'S MARRIAGE NAME: <u>Mary Swann</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.: <u>216-10-1840</u>	
17. (If yes, give war or dates of service)		18. INFORMANT & ADDRESS: <u>Elma Wilson, Ridgely, Md.</u>	
19. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<u>181X</u> Immediate cause (a) <u>Carcinoma of the bladder.</u>			
Antecedent causes (s) (b) <u>4th degree</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Generalized arteriosclerosis</u>			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. <u>Cerebral arteriosclerosis</u>			
19. DATE OF OPERATION: <u>Mar. 18, 1955</u> MAJOR FINDINGS OF OPERATION: <u>Carcinoma of bladder - moderately invasive</u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)			
PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)			
INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY			
INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>			
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 1953</u> , to <u>March 5, 1955</u> that I last saw the deceased alive on <u>May 14, 1955</u> , and that death occurred at <u>about 2 AM</u> , from the causes and on the date stated above.			
SIGNATURE (Degree or title) <u>Charles D. Unwin, M.D.</u> ADDRESS <u>Ridgely, Md.</u> DATE SIGNED <u>3.17.55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)			
DATE THEREOF <u>Mar. 18, 1955</u> NAME OF CEMETERY OR CREMATORY <u>Greenboro Cemetery</u> LOCATION (City, town, or county) (State) <u>Greenboro, Md.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>Mar. 17, 1955</u> REGISTRAR'S SIGNATURE <u>Mary E. Landry</u>			
24. FUNERAL DIRECTOR <u>J. Siegel, Mortuary Law, Newland</u> ADDRESS			

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
MAR 21 1955
BUREAU V. S.